Co-occurring Disorders 2005: Workforce Issues

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What Works: Workforce Issues

- Current Dimensions of the Workforce
- Workforce Dilemmas
- Concurrence on COD Approach
- Embracing Technologies at All Levels

Current Dimensions

- Crisis stage
  - New York Whitepaper on Addictions Workforce 2002
    - Increase in professionalism in the field including increase of addiction specialties across disciplines, but fewer people are choosing the field and there is a rise in the numbers of people leaving
    - Field is in transition from experientially trained workforce to one that emphasizes graduate training

Current Dimensions: New York

- Challenges
  - Attitudinal perspectives
  - Interdisciplinary approaches
  - Education and training
  - Recruitment and retention
  - Funding and advocacy

Current Dimensions: NAADAC Survey

- CSAT 2003 Survey of workforce
  - 70% female, 78%white, 42y/o mean
  - 40% master's degree
  - Drawn to field by personal factors
  - 50% see opportunity for career advancement

Current Dimensions: Idaho

- 2002 survey ATTC
  - 59% female, 100% white, 44 y/o mean
  - 63% BA, 28% graduate degree
  - 53% have specialized certificate
  - 94% participated in CE
  - Personal or family experience are most frequently cited reason for career
  - Turnover rate 26%

Current Dimensions: NIAAA

- Instability of workforce
  - average salary 34k
- 2000 survey
  - 40% 45 - 54 y/o, 70% female, 74% white
- Movement across employers is substantial
- Turnover is 18.5 %

COD Workforce Dilemmas

- COD is a misnomer, actually many disorders co-exist
- Demands for differential diagnosis and ability to work with many COD
- These skills are taught in graduate level programs (MSW, MSN, PhD) but most do not provide specialized training with AODA

COD Workforce Dilemmas

- The undergraduate and graduate educational programs have not fully embraced COD
- There is more potential for innovation and fewer resources to permit the innovation
- Great variation in community college certificate programs

COD Workforce Dilemmas

- Greater variation at the program/ provider/practitioner level
- Provider system remains non-integrated at the local, regional and state level
- Burnout and frustration is high at the direct-care level

Solutions to Workforce Dilemmas

Education about Consensus and Evidence-based Practices

Six Guiding Principles

Six Guiding Principles in Treating Clients With COD

1. **Employ a recovery perspective.**
2. **Adopt a multi-problem viewpoint.**
3. **Develop a phased approach to treatment.**
4. **Address specific real-life problems early in treatment.**
5. **Plan for the client's cognitive and functional impairments.**
6. **Use support systems to maintain and extend treatment effectiveness.**

Adapted from Substance Abuse Treatment for Persons With Co-Occurring Disorders TIP, 2005

Essential Programming for Clients With COD

- screening, assessment, and referral
- psychiatric and mental health consultation
- prescribing onsite psychiatrist
- medication and medication monitoring
- psycho-educational classes
- double trouble groups (onsite)
- dual recovery mutual self-help groups (offsite)

Adapted from Substance Abuse Treatment for Persons With Co-Occurring Disorders TIP, 2005

Techniques for Working With Clients With COD

- **Provide motivational enhancement to increase motivation for treatment.**
- **Design contingency management techniques to address specific target behaviors.**
- **Use cognitive–behavioral therapeutic techniques to address maladaptive thinking & behavior.**
- **Employ relapse prevention techniques to reduce psychiatric and substance use symptoms.**
- **Apply repetition and skills-building to address deficits in functioning.**
- **Facilitate client participation in mutual self-help group.**

Adapted from Substance Abuse Treatment for Persons With Co-Occurring Disorders TIP, 2005

Clinical Competencies of the Workforce

Specific Examples

COD Clinical Competencies

Integrated Diagnosis of Substance Abuse and Mental Health Treatment

- Differential diagnoses
- Terminology (definitions)
- Pharmacology
- Laboratory tests and physical examination
- Withdrawal symptoms
- Cultural factors
- Effects of trauma on symptoms
- Staff self-awareness

COD Clinical Competencies

Integrated Assessment of Treatment Needs/Appropriateness

- Severity assessment
- Lethality/risk
- Assessment of motivation/readiness for treatment
- Appropriateness/treatment selection
- Family interventions

COD Clinical Competencies

Integrated Treatment Planning

- Goal setting/problem solving
- Treatment Planning
- Documentation
  - Confidentiality
  - Legal/reporting issues
  - Documenting re: managed care issues

COD Clinical Competencies

Engagement & Education

- Staff self-awareness regarding recovery
- Engagement
- Motivating
- Educating

COD Clinical Competencies

Early Integrated Treatment Methods

- Emergency/crisis intervention
- Knowledge & access to treatment services
- When and how to refer
- Integrating/communicating

COD Clinical Competencies

Longer Term Integrated Treatment Methods

- Group treatment
- Relapse prevention
- Case Management
- Pharmacotherapy
- Alternatives/harm reduction
- Ethics, confidentiality
- Mental hygiene law, reporting requirements

Embracing Technologies at All Levels

- Undergraduate and graduate education
- Continuous education
- Judicious internet and listserv information
  - Dualdx@treatment.org
  - www.ireta.org/attc

  Systems change technology
  - Change agents at all levels
  - CQI approaches

Embracing Technologies at All Levels

- SAMHSA Office of Workforce Development rather than CSAT or CMHS
- Empowered partnering with consumers and families
- Evidence Based Practices
  - Application in the provider system

Embracing Technologies at All Levels

- Therapeutic technologies
  - MET, Contingency-based Treatment
  - Dialectical Behavior Therapy
  - Psychiatric Rehabilitation and Recovery
- Clinical supervision
- Application of cultural competence

Embracing Technologies at All Levels

- Unification of clinicians and researchers at the practice level
- Knowledge of neuropsychiatry and psychopharmacology and methods to teach such to individuals

Closing Statement

Anthony, 2004

…”I was thinking about the fact that I couldn’t remember all the principles my colleagues and I have suggested over the years… Is there not just one simple principle that transcends all others?...

….the principle of personhood..

Closing Statement

Anthony, 2004

…persons with disorders want to self-determine their own goals, be involved in their own lives, believe in their own capacity to grow and have hope…

…if the principle of personhood can transcend all of our research, training and services, good things will follow.

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